NATIONAL COMMISSION ON CORRECTIONAL HEALTH CARE

# Procedure in the Event of an Inmate Death





**A-09 Procedure in the Event of an Inmate Death (important)**

The responsible health authority conducts a thorough review of all deaths in custody in an effort to improve care and prevent future deaths.

PLAINTIFF'S EXHIBIT 5

As correctional health professionals, we strive to avoid preventable patient deaths. However, when an inmate dies, the death should be reviewed to determine the appropriateness of clinical care; to ascertain whether changes to policies, procedures or practices are warranted; and to identify issues that require further study.

The best way to answer these questions is to take a three-pronged approach to every inmate death, regardless of the cause: an administrative review, a clinical mortality review and a psychological autopsy if the death is by suicide. These three processes comprise a death review. This review is also required for deaths, whether natural or otherwise, that occur off-site while the facility is responsible for the inmate.

## Part 1: Administrative Review

Administrative reviews assess correctional and emergency response actions surrounding an inmate's death. They entail a review of the incident and facility procedures used; training received by involved staff; emergency response; and recommendations, if any, for change in policy, training, physical plant, medical or mental health services, and operational procedures. The administrative review should be conducted with the participation of custody staff.

In previous versions of this standard, the administrative review was required to occur within 30 days. In the 2018 Standards for Health Services for jails and prisons, the 30-day requirement has been eliminated. However, we recommend that a preliminary administrative review occur as soon as possible to identify any obvious areas for immediate improvement. As the administrative review continues in the months following the death (e.g., autopsy results, further findings), the review can be appended with applicable information.

## Part 2: Clinical Mortality Review

The clinical mortality review is an assessment of the clinical care provided and the circumstances leading up to a death. This review is to be conducted within 30 days to determine the appropriateness of the clinical care provided and the effectiveness of the clinical policies and procedures relevant to the circumstances surrounding the death. At least three key questions should be asked during this review: Could the medical response at the time of death be improved? Was an earlier intervention possible? Independent of the cause of death, is there a way to improve care?

Typically, clinical mortality reviews include a review of the incident and facility procedures that were implemented, training received by the staff involved, pertinent medical and mental health services, and reports involving the inmate. When a death is expected, a modified review process focusing on relevant clinical aspects of the death and the preceding treatment may be used. Similar to the administrative review, the clinical mortality review should also include recommendations, if appropriate, for changes in policy, training, physical plant, medical or mental health services, and operational procedures.

A clinical mortality review should be conducted separately from other formal investigations that might be required to determine the cause of death. It could be completed by a unit physician not involved in the patient's treatment, a central office or corporate physician, or an outside medical group.

A psychological autopsy, sometimes referred to as a psychological reconstruction or postmortem, is required within 30 days for all deaths by suicide. This written reconstruction of an individual's life emphasizes factors that may have led up to or contributed to the death. It is usually conducted by a psychologist or other qualified mental health professional and is based on a detailed review of all file information on the inmate, a careful examination of the suicide site and interviews with staff and inmates familiar with the deceased.

## Tracking Death Review Requirements

Because death reviews typically involve multiple disciplines (e.g., custody staff, health staff, mental health staff, coroner, others), investigatory documentation may not be readily available. Therefore, the 2018 standard requires that the responsible health authority maintain a log that includes the following:

- Patient name or identification number
- Age at time of death
- Date of death
- Date of clinical mortality review
- Date of administrative review
- Cause of death (e.g., hanging, respiratory failure)
- Manner of death (e.g., natural, suicide, homicide)
- Date pertinent findings of reviews shared with staff
- Date of psychological autopsy, if applicable

Maintaining a log with these components will help health care administrators ensure that all components of a death review are completed in a timely manner.

## Corrective Follow-Up

Finally, corrective actions identified through the review process should be implemented and monitored through the quality improvement program for systemic issues, and through the patient safety program for staff-related issues. Pertinent findings of death reviews should be communicated to treating staff to prevent similar situations in the future.

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BACK TO SPOTLIGHT HOME PAGE